MAINTENANCE LEVEL 2

M2-MO Health Benefit Exchange Cost Allocation PLACEHOLDER

RECOMMENDATION SUMMARY TEXT

The Health Care Authority (HCA) requests net-zero adjustments in the 2016 Supplemental due to changes in costs allocated to Medicaid and Children's Health Insurance Program (CHIP) for operational expenses incurred by the Washington State Health Benefit Exchange (HBE). This placeholder request is needed to adjust funding levels stemming from updates to factors used in determining HCA and HBE shares of these costs.

PACKAGE DESCRIPTION

In 2014, the state implemented the Affordable Care Act, which introduced modified adjusted gross income (MAGI)-based rules for Medicaid eligibility determinations through the HBE Healthplanfinder (HPF) website. Currently, over 1.4 million Medicaid and CHIP clients now have their eligibility records maintained through the HPF website and other related systems. On an ongoing basis, existing clients access the HPF to update their client records when needed, receive HPF-generated notices and other required correspondence, and access customer support services provided by the HBE operated Call Center and Navigator program.

The HBE incurs expenses for operational activities for which a portion is the responsibility of the Medicaid program. These costs are allocated using a methodology that reflects the proportion of Medicaid and CHIP clients using the HPF system and other services relative to usage by Qualified Health Plan (QHP) applicants and enrollees. Specific costs allocated to the HCA include:

- HPF Operations and Maintenance (O&M) costs (contractor activities, certain HBE staff, and software licensing fees);
- Operating costs for the HBE Call Center;
- Print Services (contractor managed correspondence services shared between the HBE and the HCA);
- Imaging Services; and
- Certain In-Person Assistor/Navigator costs for support and enrollment assistance provided to applicants.

Cost Allocation Methodology

The modular architecture of the HPF provides the starting point for determining the share of O&M costs charged to the Medicaid and CHIP programs. The initial HPF design was based on seven system modules - three modules benefited both QHP and Medicaid/CHIP eligibility and enrollment for consumers using the system. Thus, initially the Medicaid share of allocated HPF O&M costs was based on applying a factor of 42.8 percent (three divided by seven) to total HPF O&M costs.

System usage is the basis for the second step in the allocation process, and this measure relies on reported enrollment data for the Medicaid, CHIP and QHP programs. Total costs for HPF M&O are

multiplied by the factors produced in the module usage analysis described above and the resulting dollar amounts attributed to "shared" system usage are multiplied by percentages taken from comparing MAGI-Medicaid versus HBE QHP enrollment for a given period. Enrollment reported for both MAGI-based Apple Health clients compared with QHP enrollment for July 2014 indicated that 88 percent of shared costs described above were attributable to the Medicaid/CHIP programs with the balance (12 percent) attributed to the HBE QHP enrollee activity.

Changes Affecting Cost Allocation Calculations

With implementation of Medicaid Plan Selection, Medicaid clients began using the Individual Enrollment module of the HPF system, shifting the module-based "shared" system allocation factor from 42.8 percent to 57.2 percent, based on the initial system design. However, once the HBE completed the removal of premium aggregation functionality in September 2015, the basic HPF system architecture changed and the number of HPF modules was reduced from seven, to six. This change in architecture prompted the HBE and the HCA to re-examine how system costs would be allocated, going forward. This joint review is examining methods used in other jurisdictions, evaluating transaction-based options, and comparing these with simply maintaining the current method of using a simple count of modules by benefiting program. One of the primary goals in this evaluation effort is to assure maximized federal funding for HPF M&O activities into the future. The HBE and the HCA plan to reach agreement on this aspect of operations cost allocation by November 2015 and this request will be updated at that time.

Enrollment Changes

In developing future enrollment estimates for calculating the enrollment-based distributions, the HCA relied on available Caseload Forecast Council projections and the HBE on projections produced by Milliman, one of the HBE's contractors. For the 2015-2017 biennium budget, the Legislature assumed an 85 percent factor for MAGI Medicaid enrollment and a 15 percent factor for HBE QHP enrollment for both state fiscal years. Actual enrollment for MAGI-Medicaid and QHP populations have varied considerably from the earlier estimates used in developing the biennial budget. The table below summarizes these variances using reported actual values for both QHP and MAGI-Medicaid enrollees through June 2015. With the updated distributions, the QHP share shifted from just under 15 percent to about 9 percent while the Medicaid/CHIP portion increased from 85 percent to 91 percent.

	SFY 2015		SFY 2016		SFY 2017	
	QHP	Medicaid	QHP	Medicaid	QHP	Medicaid
Assumed in Approved Budget	12.4%	87.6%	14.8%	85.2%	14.9%	85.1%
June 2015 CFC Forecast	8.7%	91.3%	8.7%	91.3%	9.0%	91.0%
Actual Distributions (to date)	8.8%	91.2%	-	-	-	-

Actuals versus Estimates for Other Activity Measures

The approved 2015-2017 biennium budget for the HBE cost allocated expenses is based on initial estimates for determining the shares to be paid by Medicaid/CHIP for the HBE operated call center and for correspondence services (printing, postage, and translations). Original projections for allocating call center expenses used data from the period of initial HPF and call center operations which were not representative of "steady state" operations. Likewise, the correspondence services cost shares used

document mailing counts from that same "start up" period. With actual data available from a longer operating period, the assumed shares to be paid by Medicaid/CHIP for these two activities have shifted considerably. In the budgeted allocation, the Medicaid/CHIP share of call center operations cost had been estimated at approximately 77 percent of the total. Recent "actuals" sourced from call center billings over the last year show that the Medicaid/CHIP share of these costs are closer to 70 percent of the total. Conversely, actual statistics from correspondence services billings indicate that the Medicaid/CHIP share for these expenses is closer to 66 percent as opposed to the 62 percent share assumed in the biennial budget.

Status of Health Benefit Exchange Grant Funded Activities

Design, development, and implementation (DDI) work to operationalize the Healthplanfinder system has been largely funded through grants awarded by the Centers for Consumer Information and Insurance Oversight (CCIIO), and since the integrated system design operationalized the ACA required single, streamlined eligibility application and the MAGI-Medicaid eligibility rules, a share of these DDI costs have been allocated to the Medicaid and CHIP programs. Washington received four grant awards including a Planning Grant, three Level One Establishment Grants and a Level Two Establishment Grant for a total of $266,000,000. This funding was scheduled to end December 31, 2014 however changes in federal policy has extended the availability of grant funds for certain DDI work to further stabilize the HPF system. Due to HPF system changes stipulated by the HBE Board and the Legislature that resulted in the removal of premium aggregation, a portion of the remaining DDI work was rescheduled, supported by a limited extension of Level One Establishment (Level 1C) grant funding available now through August 2016. The DDI work planned by the HBE includes two HPF system releases with elements that will benefit Medicaid. This request includes DDI-related cost allocation amounts associated with the extended grant funding supporting these planned releases.

In addition, $4,500,000 of non-grant funding was provided by the Legislature in the 2015-2017 biennium budget. This funding is adjusted due to the updates in the cost allocation agreement.

In summary, this update reflects higher Medicaid enrollment versus lower than estimated HBE Qualified Health Plan enrollment, the impacts from changes in HPF system architecture due to the removal of premium aggregation, the extension of grant-funded DDI work and the changes resulting from more recent call center and correspondence services performance data . All of these changes impact the amount of costs allocated to the Medicaid and CHIP programs. The HCA is working with the HBE to finalize a new

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FISCAL DETAILS/OBJECTS OF EXPENDITURE

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ -	$ -	$ -
Fund 001-C GF-Federal Medicaid Title XIX	$ -	$ -	$ -
Fund 17T-1 Health Benefit Exchange	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	-	-	-

	FY 2016	FY 2017	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ -	$ -	$ -
B - Employee Benefits	$ -	$ -	$ -
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ -	$ -	$ -
G - Travel	$ -	$ -	$ -
J - Capital Outlays	$ -	$ -	$ -
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

	FY 2016	FY 2017	Total
4. Revenue:			
Fund 001-2 GF-Federal	$ -	$ -	$ -
Fund 001-C GF-Federal Medicaid Title XIX	$ -	$ -	$ -
Fund 17T-1 Health Benefit Exchange	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

NARRATIVE JUSTIFICATION

WHAT SPECIFIC PERFORMANCE OUTCOMES DOES THE AGENCY EXPECT?

Through this request, the HCA expects to remain in compliance with the federal cost allocation plan.

PERFORMANCE MEASURE DETAIL

Activity Inventory

H015 Payments to Other Entities related to Medicaid Administrative Costs and other costs paid by the Health Care Authority

IS THIS DECISION PACKAGE ESSENTIAL TO IMPLEMENT A STRATEGY IDENTIFIED IN THE AGENCY'S STRATEGIC PLAN?

Yes, request supports an Increase the number of Insured and Access to Affordable Coverage

DOES THIS DECISION PACKAGE PROVIDE ESSENTIAL SUPPORT TO ONE OR MORE OF THE GOVERNOR'S RESULTS WASHINGTON PRIORITIES?

Yes. This request supports Governor Inslee's Goal 4: Health and safe communities, Goal 1.3 Decrease the rate of uninsured in state from 15 percent to 6 percent by 2017.

WHAT ARE THE OTHER IMPORTANT CONNECTIONS OR IMPACTS RELATED TO THIS PROPOSAL?

None

WHAT ALTERNATIVES WERE EXPLORED BY THE AGENCY, AND WHY WAS THIS ALTERNATIVE CHOSEN?

None

WHAT ARE THE CONSEQUENCES OF NOT ADOPTING THIS PACKAGE?

Without this request, the methodology that is used to allocate HBE operating costs to the HCA will not be updated to accurately reflect actual usage.

WHAT IS THE RELATIONSHIP, IF ANY, TO THE STATE CAPITAL BUDGET?

None

WHAT CHANGES WOULD BE REQUIRED TO EXISTING STATUTES, RULES, OR CONTRACTS TO IMPLEMENT THE CHANGE?

None

EXPENDITURE AND REVENUE CALCULATIONS AND ASSUMPTIONS

REVENUE CALCULATIONS AND ASSUMPTIONS:

See backup, HBE Budget - Final Conference 6-29-15 (HCA Supplemental 2016 Update Version).xlsx

EXPENDITURE CALCULATIONS AND ASSUMPTIONS:

See backup, HBE Budget - Final Conference 6-29-15 (HCA Supplemental 2016 Update Version).xlsx

DISTINCTION BETWEEN ONE-TIME AND ONGOING COSTS:

Adjustments will be made annually in accordance with updated caseload and federal funding data.

BUDGET IMPACTS IN FUTURE BIENNIA:

Similar adjustments will be needed in future biennia.